MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH ★

C6938

Reg. Dist. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Winnie Brawner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 85			..... hrs. ..... min.

9. Birthplace: Waldorf, Charles, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own home

FATHER
12. Name: Charles Brawner
13. Birthplace: Chas Co

MOTHER
14. Maiden name: Lettie Green
15. Birthplace: Chas Co

16. Informant: Flora Miles

Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-15-45 (month) (day) (year)

Cemetery or crematory: Zion Wesley

Location: Waldorf Md

18. Funeral director: Smith & Ryon

Address: Waldorf Md

19. 7-11-45 (Date rec'd by registrar) M. L. Dorsett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10, 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945, to ..... 19..

and that I last saw her alive on July 10, 1945

Immediate cause of death	DURATION
Unknown but natural causes	2-3 wks.
Due to: Generalized arteriosclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Dep. Med. Examiner

23. SIGNATURE: John T. McKnight, M.D.
M. D. or other

Address: La Plata, Md. Date signed 7-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06939

Reg. Dist. No. 100

1. PLACE OF DEATH: [redacted] Charles County

City or town Hughesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Charles

City or town Hughesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME John Allen Butler

3. (b) Social Security Number none -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Gracie A. Butler

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct 4 1888

8. AGE: Years	Months	Days	If less than one day
56	10	20	hrs. min.

9. Birthplace Chas. Co Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Pierrie Butler

13. Birthplace Chas Co Md

MOTHER 14. Maiden name Mary Ellen Thomas

15. Birthplace Chas Co. Md

16. Informant Butler (wife)

Address Hughesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-27-45 (month) (day) (year)

Cemetery or crematory St Marys

Location Bryantown Md

16. Funeral director Elmer M Quade

Address Hughesville Md

19. 7-25-45 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 1145A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 7/24 1945 to [illegible] and that I last saw h[illegible] alive on July 24/45 1945

Immediate cause of death

	DURATION
Acute Cardiac Dilatation	1 min
Due to	
Due to Heart Trouble	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T O Chappelear M D Dep Coroner M. D. or other

Address Hughesville Md Date signed 7/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

C6940

★ Reg. Dist. No. 141

1. PLACE OF DEATH:

County: Charles

City or town: Hill Top

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Hill Top

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Howe. E. Dent

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Mamie E. Dent. 6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Oct 6, 1877

8. AGE:

Years	Months	Days	If less than one day
67	9	9	...hrs. ...min.

9. Birthplace: Hill Top, Chas Co. Md (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER

12. Name: Alex Dent.

13. Birthplace: Chas. Co. Md.

MOTHER

14. Maiden name: Kate Jones.

15. Birthplace: Chas. Co. Md

16. Informant: Mamie Dent

Address: Hill Top. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 45 (month) (day) (year)

Cemetery or crematory: Baptist

Location: Hill Top, Md.

18. Funeral director: Penning & Carter.

Address: Meade Springs Md

19. July 4 19 19 45 (Date rec'd by registrar) Mrs. B. F. Bowie Registrar sept.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 15 1945

and that I last saw h... alive on July 12 1945

Immediate cause of death	DURATION
Cardio-vascular renal disease.	
Due to	
Due to	
Other conditions	

(Includo pregnency within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please onderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. C. Bickwell M.D. M. D. or other

Address: Marbury Md Date signed July 19 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07431

★ Reg. Dist. No. 103

1. PLACE OF DEATH:

County Charles

City or town Dentsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 wks

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles

City or town Dentsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Leon Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17, 1945

8. AGE: Years	Months	Days	If less than one day
0	1	22	....hrs. ....min.

9. Birthplace La Plata, Charles, Md. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Reuben Dorsey

13. Birthplace Dentsville, Md.

MOTHER 14. Maiden name Carrie Hicks

15. Birthplace Newport, Md.

16. Informant Reuben Dorsey

Address Dentsville, Md.

17. ..... Date thereof ..... (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Mary's Cemetery

Location Newport - Md.

18. Funeral director Rubin Dorsey

Address Dentsville

19. July 12 1945 J. P. Tippett (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945, at about 100- 600 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1945, to ..... 19....

and that I last saw him alive on July 9, 1945

Immediate cause of death	DURATION
Prematurity	
Due to Twinning (full term but sickly) (5 lbs. 5 oz.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE James T. MacKenzie, M.D. Deputy Medical Examiner

M. D. or other

Address La Plata, Md. Date signed 7-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-0

CERTIFICATE OF DEATH

6941

Reg. Dist. No. 700

1. PLACE OF DEATH:

County Charles

City or town La Plata mt

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Md County Chas

City or town La Plata mt

(If outside city or town limits, write RURAL and give nearest town)

Street No. Benedict

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Agnes Edelen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Sngle

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1938

8. AGE: Years 7 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Rose Point md (Town, county, and state)

10. Usual occupation school

11. Industry or business

FATHER 12. Name Arthur Edelen

13. Birthplace Benedict md

MOTHER 14. Maiden name Catherine Moore

15. Birthplace Pomonkey md

16. Informant Arthur Edelen

Address Benedict md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-26-45 (month) (day) (year)

Cemetery or crematory Holy Ghost

Location La Plata md

18. Funeral director Hunt & Ryon

Address Waldorf Md

19. 7-26 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24-45 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-24-45 19..... to 7-24-45 19..... and that I last saw h... alive on 7-24-45 19.....

	DURATION
Immediate cause of death Acute food Dispepsia	48 hr
Due to Eating Spoiled meat	
Due to Possible Bacillary Dysentery	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel L Fisher M. D. or other

Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

6942

★ Reg. Dist. No. 101

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Charles

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Pisgah
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Isabella Gloden

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed.

6.(b) Name of husband or wife: John F. Gloden

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21 1861

8. AGE:

Years	Months	Days	If less than one day
83	6	23	hrs. min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Benj. Simpton.

Address: Pisgah, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 45 (month) (day) (year)

Cemetery or crematory: Pisgah Methodist

Location: Pisgah Md.

18. Funeral director: Hiett & Ryon

Address: Waldorf, Md.

19. July 17 19 45 (Date rec'd by registrar) Mary Smithmeyer Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 19 45, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 06, to July 17 19 45

and that I last saw her alive on July 16 19 45

Immediate cause of death: Cerebral Hemorrhage

Due to: Cardio renal disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Bickwell M.D.
M. D. or other

Address: Marbury, Md. Date signed: July 17 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66943

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Bel Alton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 83 yrs.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Bel Alton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Emily Hamilton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 28, 1862

8. AGE: Years	Months	Days	If less than one day
83	3	3	..... hrs. ..... min.

9. Birthplace: Bel Alton Charles Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own home

FATHER 12. Name: Francis P. Hamilton

13. Birthplace: La Plata, Md.

MOTHER 14. Maiden name: Priscilla Neale

15. Birthplace: Bel Alton, Md.

16. Informant: Mrs. M. H. Mullen (sister)

Address: Bel Alton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-45 (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Bel Alton, Md.

18. Funeral director: Hurst & Ryan

Address: Waldorf, Md.

19. 7-2 (Date rec'd by registrar) 1945 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Fall of 1945, to July 1, 1945 and that I last saw h.. alive on April 1, 1945

Immediate cause of death	DURATION
Chr. myocardial degeneration	2-3 yrs.
Due to: Generalized arteriosclerosis	10-12 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill to the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: James L. MacKaraugh, M.D. M. D. or other

Address: La Plata, Md. Date signed 7-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-B)

CERTIFICATE OF DEATH

(6944)

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Chas
City or town: Bel Alton md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter H Mudd

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-15-59

8. AGE: Years: 85 | Months: 10 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bryantown Charles, Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Penna. R.R. Co.
12. Name of father: James A Mudd
13. Birthplace of father: Bryantown md
14. Maiden name of mother: Emma Berryman
15. Birthplace of mother: Bryantown Md
16. Informant: Emma Burch
Address: Bel Alton md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2-45 (month) (day) (year)
Cemetery or crematory: St Ignatius
Location: Bel Alton md
18. Funeral director: Hamill & Penn
Address: Waldorf md
19. 8/1 (Date rec'd by registrar) 1945 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-30 1945 at 9:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1945 to 7-30 1945
and that I last saw h.. alive on 7-29 1945

Immediate cause of death	DURATION
Uremia	7-2-45
Due to: Prostatism	5-11-45
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Rodelen M.D. M. D. or other
Address: La Plata Md Date signed: 8-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

06945

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Benedict (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Temporary

Hospital, institution, or street address where death occurred: Fishing trip

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Wash. DC County: —

City or town: — (If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 Kearney St NE (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~Charles Wilbert~~ Ross, Charles Wilbert

3.(b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Maude Ross

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): July 30 1905

8. AGE: Years: 39 ~~40~~ Months: 11 Days: If less than one day ... hrs. ... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Storage

FATHER

12. Name: John Ross

13. Birthplace: Nanjemoy, Md

MOTHER

14. Maiden name: Elizabeth Moore

15. Birthplace: Md

16. Informant: Mrs Maude Ross

Address: 1431 Kearney St N.W. Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24 1945 (month) (day) (year)

Cemetery or crematory: Oak Grove

Location: Nanjemoy Md

18. Funeral director: Barnes & Matthews

Address: 614 4 St S.W. Washington DC

July 22 1945 (Date rec'd by registrar) M. L. Monroe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1945, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/22 1945, to July 22 1945 and that I last saw h... dead ~~alive~~ on 7/22/45 19...

Immediate cause of death: Coroner's Inquest

Drowning

Due to: (accidental) fell off boat

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 7/22/45

Where did injury occur? Benedict Chas Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Dep. Coroner

23. SIGNATURE: T. A. Chapple MD M. D. or other

Address: Hughesville Date signed: 7/22/45

Miss Monroe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

6946

★ Reg. Dist. No. 10-102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Doorty Charles
City or town: Pridston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Charles
City or town: Drayton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nancy Lee Scott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John T. Scott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11 1854

8. AGE: Years	Months	Days	If less than one day
90	8	17	hrs. min.

9. Birthplace: King George Co. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William Sorrell.
13. Birthplace: King George Co. Va.
MOTHER 14. Maiden name: Middleton.
15. Birthplace: Stafford Co. Va.
16. Informant: Albert Scott
Address: Nanjemoy, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 33 45 (month) (day) (year)
Cemetery or crematory: Babbett
Location: Nanjemoy, Md.
18. Funeral director: Hebbt & Reyon
Address: Waldorf Md
19. July 29 1945 (Date rec'd by registrar) Mary Isom Tennant Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1945 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1945 to July 29 1945 and that I last saw her alive on July 27th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee C. Bickell M.D.
M. D. or other
Address: Marlboro Md Date signed: July 29 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16947

Reg. Dist. No. 104

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Charles Co. Cobb Island

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: D. C.

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Mass. Ave. N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John T. Spencer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	widowed

6.(b) Name of husband or wife: Mary E. Spencer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1885

8. AGE: Years	Months	Days	If less than one day
60	0	27	hrs. min.

9. Birthplace: South Mills, N. C. (Town, county, and state)

10. Usual occupation: Conductor - P. R. R.

11. Industry or business

FATHER 12. Name: John Spencer

13. Birthplace: N. C.

MOTHER 14. Maiden name: Amanda Lydia Taylor

15. Birthplace: N. C.

16. Informant: L. L. Atchison

Address: 208 Mass. Ave. N. E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1945 (month) (day) (year)

Cemetery or crematory: Media Cemetary

Location: Media, Pa.

18. Funeral director: James William Lee

Address: 4th and Mass. Ave. N.E. Washington D.C.

19. 7/7 1945 (Date rec'd by registrar) William J. Fiore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945, at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19...; and that I last saw h... alive on ... 19...

Immediate cause of death	Apoplexy	DURATION
Due to		
Due to		
Other conditions		

(Includo pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. L. Atchison, M. D. or other

Address: Wayside Date signed 7-7-45